Date of Hearing: June 30, 2026

ASSEMBLY COMMITTEE ON JUDICIARY
Ash Kalra, Chair
SB 28 (Umberg) – As Amended June 25, 2026

As Proposed to be Amended

SENATE VOTE: NOT RELEVANT

SUBJECT: COMMUNITY ASSISTANCE, RECOVERY, AND EMPOWERMENT (CARE) COURT PROGRAM

SYNOPSIS

Senate Bill 1338 (Umberg), Chapter 319, Statutes of 2022, established the Community Assistance, Recovery, and Empowerment (CARE) Act, which provides community-based behavioral health services and supports, by means of a civil court process, to Californians living with untreated schizophrenia spectrum or other psychotic disorders. The CARE Act is intended to serve as an upstream intervention for individuals experiencing severe impairment to prevent more restrictive alternatives, including psychiatric hospitalizations, incarceration, Assisted Outpatient Therapy, and Lanterman-Petris-Short (LPS) conservatorships. This bill is the latest in a series of seemingly annual bills to modify the CARE Act. The bill proposes a number of changes to the CARE Act, including expanding the scope of evidence that can be considered as part of a CARE petition, requiring the development of a model exit plan for individuals that may need a higher level of care than available through the CARE process, allowing courts to adopt CARE agreements as CARE plans under specified circumstances, and establishing a CARE Court ombudsperson to oversee complaints regarding the program, among other things.

Given the time pressures to hear this recently amended bill, minimal amendments are proposed to be taken at the Committee's hearing. However, further recommendations are described in the analysis. This bill is author-sponsored and enjoys the support of the California State Association of Psychiatrists and two members of the public. This bill is also opposed by a number of organizations, including civil rights advocacy organizations, disability rights organizations, and organizations representing county behavioral health agencies, as well as public guardians, conservators, and administrators. This bill was recently approved by the Assembly Health Committee 14-0.

SUMMARY: Makes a number of changes to the CARE Act, including expanding the scope of evidence that can be considered as part of a CARE petition, requiring the development of a model exit plan for individuals that may need a higher level of care than available through the CARE process, and establishing a CARE Court ombudsperson to oversee complaints regarding the program, among other things. Specifically, **this bill**:

1) Provides that if, upon the termination of an initial or a succeeding period of conservatorship, the conservator determines that conservatorship is no longer required but additional help is still warranted, the conservator may request the court to refer the conservatee to the CARE Act court. Requires documentation of the authority for a referral to be signed by a physician or licensed psychologist. Specifies that the referral must confirm that the conservatee is no

longer gravely disabled as a result of mental disorder or impairment by chronic alcoholism and meets, or is likely to meet, criteria to qualify for the CARE process.

2) Allows a CARE petition to include evidence that the respondent was detained for a minimum of two involuntary 5150 holds in the previous 120 days and evidence that the respondent was referred to a full-service partnership program more than once, but was not enrolled due to inability or unwillingness to engage in the previous 120 days.

3) Specifies that, beginning July 1, 2028, if the court dismisses a CARE petition because a respondent needs a higher level of services, the court may order the county to develop an exit plan for the respondent.

4) Requires the Department of Health Care Services, no later than July 1, 2028, to develop, with input from a stakeholder group, a CARE Act model exit plan that identifies appropriate services and ongoing monitoring of an individual with a petition dismissed from the CARE Act because the court determined that they need a higher level of services. Requires the stakeholder group to include, at a minimum, county behavioral health agencies, county CARE courts, racial justice experts, and other appropriate stakeholders, including providers and CARE court participants.

5) Allows the court to adopt the CARE agreement as a CARE plan if all of the following are true:

   a) The respondent has stopped engaging with the CARE process for 60 days or more despite documented attempts by the county, local agency, or treatment providers to maintain engagement with the respondent.

   b) All elements of the CARE agreement have been provided to the respondent by the county or other local agency, as required.

   c) The court finds that a CARE plan would be a more effective alternative than potential dismissal from the CARE process.

6) Specifies that the adoption of the CARE agreement as a CARE plan will not reset the one-year timeline in the CARE process.

7) Specifies that 5) does not limit or alter the court's authority to adopt a CARE plan pursuant to existing law.

8) Allows parties and witnesses to appear remotely through the use of remote technology for the hearings described in the CARE Act. Specifies that a court has the discretion to order a party or witness to appear in person, if necessary.

9) Specifies that all subsequent reports and notices served after the notice of initial appearance on the CARE petition may be served through alternative methods of service agreed to by the parties.

10) Requires all counties, by January 1, 2028, to establish a process for electronic submission of CARE Act documents using a secured portal.

11) Requires a behavioral health professional or their designee to confirm that they believe the individual meets or is likely to meet the CARE Act eligibility criteria for a referral from an LPS designated facility to the CARE program.

12) Specifies that an expedited assessment may be necessary for referrals from an LPS-designated facility to the CARE program where there is concern of imminent discharge and foreseeable challenges with locating the respondent.

13) Requires the court to make findings on the record about the basis for termination of the respondent's participation in the CARE process.

14) Provides that, the court must not terminate the respondent's participation in the CARE process solely due to a failure of the county or other local government entity to properly engage with the CARE process.

15) Specifies that the same data that is tracked for former participants pursuant to existing law must also be tracked for cases involving dismissed respondents.

16) Specifies that the trial courts must report to the Judicial Council the following additional data related to CARE Act petitions:

    a) The number of petitions submitted electronically.

    b) The number of declarations of licensed behavioral health professionals pursuant to the form prepared by the Judicial Council submitted electronically.

    c) The number of petitions that were dismissed for failure to make a prima facie showing.

    d) The total number of court-ordered mental evaluations ordered by the CARE court.

17) Specifies that the annual CARE Act report must include all of the following additional information compiled from county behavioral health departments and courts:

    a) The number of individuals who were referred to a full-service partnership program after dismissal or termination from the CARE Act program.

    b) The number of individuals who were enrolled in a full-service partnership program postreferral.

    c) The number of individuals who maintained enrollment in a full-service partnership program for a year following the date of enrollment.

18) Provides that consistent with existing law, the county behavioral health agency may disclose to a provider of health care, or a covered entity, any information, including protected health information, and mental health records excluding psychotherapy notes, in its possession about the respondent that is relevant to the provider or entity's provision, coordination, or management of services and supports, including, but not limited to, the preparation of any required investigations, evaluations, or reports. Specifies that such a disclosure is a disclosure for treatment purposes, which may be made only to the extent permitted under existing law. The information disclosed may include substance use disorder patient records only to the extent permitted by federal law.

19) Specifies that the county behavioral health agency cannot be held civilly or criminally liable for any disclosure authorized or required.

20) The county behavioral health agency shall notify the respondent of a disclosure pursuant to 18) as follows:

    a) By mail at the respondent's last known address, if any.

    b) To the respondent's counsel.

    c) By including a copy of the notification with the notice of the next hearing served upon the respondent, if any.

21) Specifies that all information, including the facts and records, or summary thereof, shared pursuant to 18) must further be disclosed to the respondent and the respondent's counsel and with the consent of the respondent, to the supporter, and the original petitioner, if participating in the ongoing proceedings.

22) Specifies that information disclosed to a provider of health care or a covered entity by a county behavioral health agency is confidential and not subject to disclosure under the California Public Records Act.

23) Allows reports generated by the county behavioral health agency during the CARE process to be disclosed to a provider of health care or a covered entity, if necessary to assist with ongoing treatment of the respondent.

24) Allows an evaluation of a petition to be provided to the petitioner and the licensed behavioral health professional who submitted the declaration pursuant to the form prepared by the Judicial Council.

25) Specifies that a clinical evaluation of the respondent may be provided to the original petitioner, if participating in ongoing proceedings, if the respondent consents.

26) Specifies the Assisted Living Waiver program and the Home- and Community-based Services Waiver program as federal housing programs to be considered for the respondent's CARE plan.

27) Specifies that it is the intent of the Legislature to identify appropriate metrics of success to measure counties successfully implementing the CARE Act and counties experiencing challenges with implementation who need technical support and training.

28) Requires the California Health and Human Services Agency to annually release a list identifying overperforming counties, known as CARE Champions.

29) Requires the California Health and Human Services Agency to annually provide a written notice identifying areas of concern and opportunities for improvement for underperforming counties.

30) Establishes within the California Health and Human Services Agency the position of CARE Court Ombudsperson. Specifies that the CARE Court Ombudsperson will be appointed by the Governor and confirmed by the Senate.

31) Requires the CARE Court Ombudsperson to oversee and investigate complaints by petitioners, respondents, participants, and governmental agencies involved in the CARE process, including, but not limited to, judges, county staff, first responders, and city staff.

EXISTING LAW:

1) Establishes the LPS Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. (Welfare and Institutions Code Section 5000 *et seq*. All further statutory references are to this code, unless otherwise indicated.)

2) Defines the following for the purposes of the LPS Act:

   a) "Evaluation" consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions as may appear to constitute a problem.

   b) "Intensive treatment" consists of such hospital and other services as may be indicated. Intensive treatment shall be provided by properly qualified professionals and carried out in facilities qualifying for reimbursement under the Medi-Cal or Medicare program. Intensive treatment may be provided in hospitals of the United States government by properly qualified professionals.

   c) "Gravely disabled" means any of the following, as applicable:

      i. A condition in which a person, as a result of a mental health disorder, a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care.

      ii. A condition in which a person has been found mentally incompetent and specified facts exist. (Section 5008.)

3) Provides that when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. (Section 5150.)

4) Specifies that if a person is detained for 72 hours under Section 5150, or under court order for evaluation, and has received an evaluation, the person may be certified for not more than 14 days of intensive treatment related to the mental health disorder or impairment by chronic alcoholism, under the following conditions:

a) The professional staff of the agency or facility providing evaluation services has analyzed the person's condition and has found the person is, as a result of a mental health disorder or impairment by chronic alcoholism, a danger to others or to themselves, or is gravely disabled.

b) The facility providing intensive treatment is designated by the county to provide intensive treatment and agrees to admit the person. A facility will not be designated to provide intensive treatment unless it complies with the certification review hearing required by the LPS Act. The procedures must be described in the county Short-Doyle plan.

c) The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.

d) A person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, or shelter. (Section 5250.)

5) Establishes the Community Assistance, Recovery, and Empowerment (CARE) Act, which provides community-based behavioral health services and supports, by means of a civil court process, to Californians living with untreated schizophrenia spectrum or other psychotic disorders that meet specified criteria. (Section 5970 *et seq.*)

6) Defines the following terms:

a) "CARE agreement" means a voluntary settlement agreement entered into by the parties. A CARE agreement includes the same elements as a CARE plan to support the respondent in accessing community-based services and supports.

b) "CARE plan" means an individualized, appropriate range of community-based services and supports, which include clinically appropriate behavioral health care and stabilization medications, housing, and other supportive services, as appropriate.

c) "Petitioner" means the person who files the CARE Act petition with the court.

d) "Respondent" means the person who is the subject of the petition for the CARE process.

e) "Supporter" means an adult designated by the respondent who assists the person who is the subject of the petition for the CARE process, which assistance may include supporting the person to understand, make, communicate, implement, or act on their own life decisions during the CARE process, including a CARE agreement, a CARE plan, and developing a graduation plan. (Section 5971.)

7) Specifies that an individual will qualify for the CARE process only if all of the following criteria are met:

a) The person is 18 years or older.

b) The person is currently experiencing a serious mental health disorder and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, or bipolar I disorder with psychotic features, except psychosis related to current

intoxication, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. Specifies that the statute does not establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions. Specifies that a person who has a current diagnosis of substance use disorder, as defined, but who does not also meet the required criteria will not qualify for the CARE process.

c) The person is not clinically stabilized in ongoing voluntary treatment.

d) At least one of the following is true:

i. The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

ii. The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined.

e) Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.

f) It is likely that the person will benefit from participation in a CARE plan or CARE agreement. (Section 5972.)

8) Allows the following adult persons to file a petition to commence the CARE process:

a) A person with whom the respondent resides.

b) A spouse, parent, sibling, child, or grandparent or an individual who stands in loco parentis to the respondent.

c) The director of a hospital or director's designee in which the respondent is hospitalized.

d) The director of a public charitable organization, agency, or home, or their designee, who has within the previous 30 days, provided or who is currently providing behavioral health services to the respondent or in whose institution the respondent resides.

e) A licensed behavioral health professional, or their designee, who is, or has been within the previous 30 days, either supervising the treatment of, or treating the respondent for a mental health illness.

f) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician, mobile crisis response worker, or homeless outreach worker, who has had repeated interactions with the respondent in the form of multiple arrests, multiple "5150" detentions and transportation pursuant, multiple attempts to engage the respondent in voluntary treatment, or other repeated efforts to aid the respondent in obtaining professional assistance.

g) The public guardian or public conservator, or their designee, of the county in which the respondent resides or is found.

h) The director of county behavioral health agency, or their designee, of the county in which the respondent resides or is found.

i) The director of county adult protective services, or their designee, of the county in which the respondent resides or is found.

j) The director of California Indian health services program, California tribal behavioral health department, who has, within the previous 30 days, provided or who is currently providing behavioral health services to the respondent, or the director's designee.

k) The judge of a tribal court located in California before which the respondent has appeared within the previous 30 days, or the judge's designee.

l) The respondent. (Section 5974.)

9) Requires the Judicial Council to develop a mandatory form for use to file a CARE process petition with the court and any other forms necessary for the CARE process. Requires the petition to be signed under penalty of perjury and contain all of the following:

a) The name of the respondent and, if known, the respondent's address.

b) The petitioner's relationship to the respondent.

c) Facts supporting the petitioner's assertion that the respondent meets the CARE criteria.

d) Either of the following:

i. An affidavit of a licensed behavioral professional, including, nurse practitioners and physician assistants, stating that the licensed behavioral health professional or their designee has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine, but has not been successful in eliciting the cooperation of the respondent, or has reason to believe, explained with specificity in the affidavit, that the respondent meets the diagnostic criteria for CARE proceedings.

ii. Evidence that the respondent was detained for a minimum of two intensive treatments, as defined, the most recent one within the previous 60 days. Evidence may include, but is not limited to, documentary evidence from the facility where the respondent was detained, or a signed declaration from the petitioner if the petitioner had personal knowledge of the detentions. (Section 5975.)

10) Specifies that if, at any time during CARE court proceedings, the court determines by clear and convincing evidence that the respondent is not participating in the CARE process, after the respondent receives notice, or is not adhering to their CARE plan, after the respondent receives notice, the court may terminate the respondent's participation in the CARE process. (Section 5979 (a).)

11) Specifies that a court may, to ensure the respondent's safety, utilize existing legal authority to order an LSP mental health evaluation. Requires the court to provide notice to the county behavioral health agency and the Office of the Public Conservator and Guardian if the court utilizes that authority. (*Id.*)

12) Specifies that if the respondent was timely provided with all of the services and supports required by the CARE plan, the fact that the respondent failed to successfully complete their plan, will be a fact considered by the court in a subsequent hearing under the LPS Act, provided that the hearing occurs within six months of the termination of the CARE plan and will create a presumption at that hearing that the respondent needs additional intervention beyond the supports and services provided by the CARE plan. (*Id*.)

13) Requires the Department of Health Care Services to develop, in consultation with county behavioral agencies, other relevant or local government entities, disability rights groups, individuals with lived experience, families, counsel, racial justice experts, other appropriate stakeholders, an annual CARE Act report. Requires the department to post the report on its internet website. (Section 5985 (a).)

FISCAL EFFECT: As currently in print this bill is keyed fiscal.

COMMENTS: Senate Bill 1338 (Umberg), Chap. 319, Stats. 2022, established the Community Assistance, Recovery, and Empowerment (CARE) Act, which provides community-based behavioral health services and supports, by means of a civil court process, to Californians living with untreated schizophrenia spectrum or other psychotic disorders who meet certain health and safety conditions. The CARE Act is intended to serve as an upstream intervention for individuals experiencing severe impairment to prevent more restrictive alternatives, including psychiatric hospitalizations, incarceration, Assisted Outpatient Therapy (AOT), and Lanterman-Petris-Short (LPS) conservatorship. This bill is the latest in a series of annual bills to modify the CARE Act which has only been in effect statewide since December 1, 2024. The bill proposes a number of changes to the CARE Act, which modify the scope of evidence that can be considered in the petition, allow for the adoption of a CARE agreement as a CARE plan, and require the development of a model exit plan from CARE court for individuals requiring a higher level of care, among other things. According to the author:

> SB 28 addresses gaps in the current CARE Act program (colloquially known as CARE Court) by ensuring greater accessibility and accountability throughout the process. Now that CARE Court has been active for nearly three years, there is clear data and evidence of unintended implementation issues. Therefore, SB 28 is desperately needed to reform several CARE Court procedures and create more accountability.

Background – CARE Act. A central feature of the CARE Act are "CARE Courts," intended to deliver mental health and substance use disorder services as an alternative to incarceration in a jail or psychiatric facility of a person with schizophrenia or another psychotic disorder, or to that person becoming subject to an LPS conservatorship. The CARE Act provides for court-ordered CARE plans for persons suffering from a mental health crisis for up to 12 months, with possible extensions. The plan is supposed to provide individuals with clinically appropriate, community-based services. These might include court-ordered stabilization medications, wellness and recovery support, help with finding social services and housing.

This bill makes several major changes to the CARE Act, which are specified in detail below. Other minor provisions of the bill, include additional data collection requirements for the annual CARE Act report, provisions allowing for the use of alternative methods of service for notices issued as part of the CARE process, the development of an electronic submission process for

CARE petitions, and other technical aspects of the program that may not be within this Committee's jurisdiction, and as such, are not discussed in this analysis.

Expanding the scope of evidence within a CARE petition. The first step in the CARE Court process is a "referral" – that is, a petition to the court by a family member, mental health provider, or first responder, among others. As part of the implementation of the Act, the Judicial Council was required to develop a CARE process petition form that can be filed with the court. (Section 5975.) The petition has to be signed under penalty of perjury and must contain specified information. (*Id.*) In addition to specified contact information and any facts supporting the petitioner's contention that the respondent meets the CARE eligibility criteria, the petition must include either: 1) a declaration from a licensed behavioral health professional attesting that the professional has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine them, and that the respondent meets the diagnostic criteria for CARE proceedings; or 2) evidence that a respondent was detained for a minimum of two intensive treatments with the most recent one being within the previous 60 days. (*Id.*)

Right now, without an affidavit from the licensed behavioral health professional or evidence of detention for two intensive treatments, a CARE petition is considered incomplete. This bill makes changes to the petition form and allows two additional forms of evidence of a person's condition to be submitted in addition to the two identified above. Specifically, the bill allows a petitioner to submit evidence that a respondent was detained for a minimum of two "5150" holds in the previous 120 days and evidence that the respondent was referred to a full-service partnership program (i.e., recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental health disorders) more than once, but was not enrolled due to an inability or unwillingness to engage in the previous 120 days. The bill also allows the affidavit from the licensed behavioral health professional and the evidence of the two intensive treatment detentions to be within the previous 120 days, rather than 60 days.

While a respondent must still qualify for the CARE process by meeting the eligibility criteria before being admitted into the program, stakeholders have suggested that expanding the scope of the evidence considered in the petition expands the eligibility criteria for CARE Court. To be sure, the number of completed petitions will likely increase given the expansion of the evidence petitioners can submit; however, the court is still required to make a determination as to whether the petition itself makes a prima facie showing that a respondent meets the eligibility criteria. (*Id.*) That being said, there is a serious question as to whether this additional evidence will provide courts with an accurate picture of an individual's mental health condition as they make this determination.

The LPS Act provides for the "5150" hold and the detentions for the two intensive treatments described above. For a 5150 hold, a peace officer, or an individual or facility authorized by the county may involuntarily detain a person for up to 72 hours for an assessment, evaluation and crisis intervention, or placement for evaluation and treatment in a facility designated by the county if they are determined to be, because of a mental health disorder, a threat either to themselves or to others, or gravely disabled. Following a 72-hour hold, the individual may be held for an additional 14 days of intensive treatment pursuant to Section 5250, if they are found to still be, because of a mental health disorder, a threat to themselves or others, or gravely disabled. As pointed out during the hearing for the Assembly Committee on Health on June 23, 2026, two 5150 holds could occur in a single day. Those holds could also be initiated by law

enforcement as opposed to a designated clinician. Further, there are individuals who have been improperly detained pursuant to this authority. By contrast, when a person is certified for intensive treatment under Section 5250, the individual is entitled to a certification review hearing. (Section 5256.)

The author may wish to reconsider the inclusion of only two 5150 holds as part of the petition.

Stepping down from LPS conservatorships to CARE court. The LPS Act also provides for conservatorships, resulting in involuntary commitment for the purposes of treatment, if an individual is found to meet the "grave disability" standard. The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled individual. The individual for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement, and they have the right to be represented by counsel. The LPS temporary conservatorship lasts for 30 days unless the person is awaiting a court or jury trial on the issue of whether they are gravely disabled, in which case the conservatorship may be extended up to six months. A permanent conservatorship lasts for one year and can be renewed.

Under current law, individuals can also become connected with CARE court if the court refers an individual from an LPS conservatorship to the program. (Section 5978.) According to the author, concerns have been raised about the abuse of step-down referrals from conservatorships to CARE court, including concerns that public guardians are not heeding the medical advice of clinicians and pursuing the step-down regardless.

This bill specifies that if upon the termination of a conservatorship, the conservator determines that additional help for the conservatee may still be warranted, the conservator can request that the court refer the conservatee to CARE court. In order to do so, the bill requires a licensed physician or psychologist to confirm the conservatee is no longer gravely disabled and meets the CARE Act eligibility criteria. While it appears all stakeholders agree that anyone who still meets the gravely disabled criteria should not be improperly removed from a conservatorship, it appears there is some disagreement as to the logistics of the referral. County stakeholders are concerned because once a person is determined to be "no longer gravely disabled," the court is required to act immediately and that could mean potentially ending the conservatorship before the county has had a chance to connect them to CARE court. Given the underlying agreement surrounding the policy goals, the author is encouraged to work with county stakeholders to mitigate potential challenges for conservatees who could eventually benefit from CARE court.

Dismissals from CARE court involving individuals requiring higher levels of care. According to the author, implementation data shows an ongoing gap between CARE Court and higher levels of care. The author contends that a number of dismissals are occurring because a respondent needs a higher level of care than available through the CARE process. While some counties have identified that they continue to monitor and check in with individuals dismissed from CARE, it is unclear which counties are doing so, and which services are being provided, when they do so.

To address these concerns, the bill now requires the Department of Health Care Services, with input from a stakeholder group, to develop a model exit plan that identifies appropriate services and ongoing monitoring of an individual who was dismissed from the CARE court program because they need a higher level of care. The department will have until July 1, 2028 to develop

the plan, and as of that date, if a court dismisses a CARE petition because a respondent needs a higher level of care, the court may order the county to develop an exit plan for the respondent. This approach is intended to ensure that individuals who come through the system are connected with services, even if CARE court is not the right program for their needs.

Adopting a CARE agreement as a CARE plan. Under the CARE Act, respondents can enter into a CARE agreement or a CARE plan. A CARE agreement includes the same elements as a CARE plan. (Section 5971 (a) – (b).) Both are designed to identify a range of appropriate community-based services and supports, which can include behavioral health care, housing and other supportive services. (*Id.*) The CARE agreement is defined as a voluntary settlement agreement, which the court can modify and approve. (*Id.*; Section 5977.1.) By contrast, the court only orders the parties to develop a CARE plan if a CARE agreement is unlikely to be reached. (Section 5977.1.)

This bill provides the court with additional authority to adopt a CARE agreement as a CARE plan if all of the following circumstances are true:

- The respondent has stopped engaging with the CARE process for 60 days or more despite document attempts by county, local agency, or treatment providers to maintain engagement with the respondent.

- All elements of the CARE agreement have been provided to the respondent by the county or other local agency, as required; and

- The court finds that a CARE plan would be a more effective alternative than potential dismissal from the CARE process.

Again, the author has introduced this provision into the bill because of concerns surrounding the implementation of the program. In this case, the author is concerned that courts are not ordering CARE plans. Failure to successfully complete a CARE plan can be considered in a subsequent LPS conservatorship hearing and will create a presumption that the respondent needs additional intervention beyond the services provided by the CARE plan. (Section 5979 (a).) Beyond this presumption, there are no consequences for an individual who fails to adhere to a CARE plan. Because the CARE process is voluntary, the court has no mechanism for truly enforcing the order. Accordingly, it is not surprising that courts are not exercising their discretion to order these plans.

With that in mind, it is unclear whether courts will begin adopting CARE agreements as CARE plans should this provision be enacted. If courts are not exercising their existing authority to order these plans now, it is unlikely they will do so following the passage of this bill, given the permissive nature of this authority. Finally, it is worth considering whether the lack of CARE plans is truly problematic. To be sure, if individuals were not entering into CARE agreements, this could suggest that there are underlying problems with implementation of the program. However, the lack of CARE plans may simply suggest that counties and courts are finding more success through entering into voluntary agreements and working collaboratively with respondents. Ultimately, the number of CARE plans ordered may not be an appropriate metric of the success of the overall program.

Assessing county implementation of CARE court. In March of this year, Governor Newsom publicly identified 10 counties as "CARE Champions." (Governor Gavin Newsom, Governor

Newsom announces new CARE Court accountability measures to get more chronically mentally ill off our streets, awards $291 million in funding for services and housing, (March 2, 2026) available at: https://www.gov.ca.gov/2026/03/02/governor-newsom-announces-new-care-court-accountability-measures-to-get-more-chronically-mentally-ill-off-our-streets-awards-291-million-in-funding-for-services-and-housing/.) According to the press release, this designation reflected that these counties had "successfully implemented CARE Court within their communities and [had] the highest rates of petitions on a per capita basis." (*Id.*) The Governor also identified 10 underperforming counties as "CARE ICU" (Improvement and Coordination Unit) counties. (*Id.*)

Following the release of the CARE Champion and CARE ICU lists, some stakeholders took issue with the metrics being used to assess county success in implementing the program. As others have pointed out, the rates of petitions on a per capita basis reveal nothing about outcomes of individuals in the program.

To that end, the author took amendments in the Assembly Committee on Health to clarify that it is the intent of the Legislature to identify appropriate metrics of success to measure implementation of the CARE Act. The author similarly agrees to take the following amendments in this Committee to ensure that, counties struggling with implementation of the Act are not simply being publicly admonished but are being provided with actionable feedback to assist with their improvement.

> (e) ***(1)*** It is the intent of the Legislature to identify appropriate metrics of success to measure counties successfully implementing the CARE Act~~, known as CARE Champions,~~ and counties experiencing challenges with implementation who need technical support and training~~., known as CARE ICU (Improvement and Coordination Unit) Counties.~~ The agency shall annually release a list identifying overperforming ~~and underperforming counties to receive additional support through CARE ICU~~. ***counties, known as CARE Champions. For underperforming counties, the agency shall annually provide a written notice identifying areas of concern and opportunities for improvement.***
>
> ***(2) Nothing in this subdivision shall any alter existing obligations to produce records under the California Public Records Act.***

Creating a central location for participants to express their complaints. The bill also establishes a CARE Court Ombudsperson within the California Health and Human Services Agency. The purpose of this position is to provide all participants with a forum for their complaints. Under this bill, the CARE Court Ombudsperson is tasked with overseeing and investigating complaints by petitioners, participants, and governmental agencies involved in the CARE process, including but not limited to judges, county staff, first responders, and city staff. While the bill in print clearly contemplates that all participants will be able to take advantage of the ombudsperson's services, some stakeholders have questioned whether respondents were exempt from these provisions, given their exclusion from the above list of participants. Accordingly, the author has agreed to take the following amendment to make it abundantly clear that respondents too can submit complaints to the CARE Court Ombudsperson.

(b) The CARE Court Ombudsperson shall oversee and investigate complaints by petitioners, ***respondents,*** participants, and governmental agencies involved in the CARE process, including, but not limited to, judges, county staff, first responders, and city staff.

Disclosures of protected health information. Finally, the bill provides for various disclosures of protected health information with health care providers and covered entities for the purpose of facilitating treatment and care for the respondent. Most of the provisions related to the disclosures appear to require compliance with existing state and federal privacy laws. However, there are some provisions of the bill that suggest that evaluations done by the county pursuant to the process can be provided to a licensed behavioral health professional that provides a declaration as part of the initial petition, even if that professional is not involved in the respondent's ongoing treatment and care. It is unclear what purpose the sharing of this information would serve, and the *author may wish to consider limiting the sharing of evaluations and other reports generated as part of the CARE process with providers who are actually involved in the respondent's treatment and care.*

ARGUMENTS IN SUPPORT*:* In support of the bill, the California State Association of Psychiatrists posits:

SB 28 strengthens linkages between Lanterman-Petris-Short (LPS) conservatorships and the CARE Court program. As a result, individuals leaving conservatorship who continue to require intensive community support will be more likely to receive ongoing treatment and supervision. SB 28 helps avoid the unfortunate scenario in which a conservatorship is terminated, and an individual is left without adequate care in the community.

[…]

By allowing prior 5150 holds and an inability to enroll in a Full-Service Partnership program to serve as evidence supporting CARE Act eligibility, SB 28 provides city agencies with practical documentation that can support CARE petitions. This change will make CARE Court more accessible to individuals who are chronically gravely disabled and repeatedly cycle through emergency departments, psychiatric hospitals, jails, homelessness, and other acute settings.

Importantly, SB 28 permits the sharing of CARE Act information among behavioral health professionals, helping ensure continuity of care when individuals transition into acute treatment settings. Current CARE Court confidentiality requirements can impede effective coordination among treating professionals, particularly when a CARE respondent requires treatment in an emergency department or inpatient psychiatric setting. By facilitating communication among behavioral health providers, SB 28 improves care coordination and reduces barriers to treatment.

[…]

SB 28 also creates a pathway from a court-supervised CARE agreement to a court-ordered CARE plan, accompanied by enhanced county accountability measures. The legislation explicitly recognizes cities first responder agencies as key stakeholders in CARE Court's success. Finally, SB 28 establishes a CARE Court Ombudsperson to investigate and review complaints from petitioners, participants, and governmental agencies involved in the CARE process.

Together, these reforms strengthen CARE Court's ability to identify, engage, and support individuals with the most serious mental illnesses while improving accountability, continuity of care, and coordination across systems. SB 28 recognizes that individuals with the most severe mental illnesses often require coordinated interventions across multiple systems and levels of care, and it ensures that CARE Court functions as a bridge to treatment rather than a dead end.

***ARGUMENTS IN OPPOSITION**:* A previous version of this bill was opposed by a broad coalition of organizations, including those dedicated to advancing civil rights, and disability rights. Collectively these groups submit.

SB 28 was substantially amended on June 11, 2026 after advancing through much of the legislative process as a different bill. These sweeping changes late in the legislative process deprive stakeholders and impacted communities of a full opportunity to evaluate the bill's significant civil rights or budget implications. This late-stage gut-and-amend approach continues a troubling pattern of advancing major CARE Court expansions without adequate opportunity for public input.

[…]

SB 28 increases coercion in the CARE Court process by allowing CARE agreements to be converted into CARE plans when a person disengages from the process. Instead of respecting a person's decision about their own care, the bill allows the court to impose a mandatory CARE plan if engagement falters, turning what is meant to be a voluntary pathway into a coercive one. This dynamic creates pressure to comply out of fear of escalation, rather than fostering genuine engagement in services, and undermines trust in both providers and the system as a whole.

In addition, SB 28 weakens privacy protections by allowing CARE Court reports to be disclosed to health care providers "if necessary to assist with ongoing treatment." This broad and vague standard creates significant discretion to share highly sensitive health information beyond the immediate CARE team. This type of information sharing can undermine trust between individuals and their providers, making people less likely to seek care or speak openly about their needs.

[…]

CARE Court is a new program that has not yet demonstrated improved outcomes. In fact, early data shows a majority of CARE Court respondents are not being connected with court-ordered services and that outcomes are poor. SB 28 would significantly expand CARE Court's scope and intensify its coercive features before the efficacy of the program is adequately determined. This bill diverts resources from the kinds of investments that are proven to support recovery, like housing and community-based treatment.

California should prioritize expanding access to low-barrier, evidence-based services that people can choose—not court-based processes that increase coercion and involvement in the legal system.

Similarly, representatives of counties, county behavioral health agencies, and public administrators, guardians, and conservators are opposed to the previous version of the bill. Based

on communications with Committee staff, these representatives remain opposed to the bill despite significant amendments taken in the Assembly Committee on Health. The County Behavioral Health Directors Association, the California State Association of Counties, the Urban Counties of California, the Rural County Representatives of California, and California State Association of Public Administrators and Public Guardians and Public Conservators submit many concerns, including but not limited to the following:

> SB 28 proposes significant changes to both the CARE and LPS Acts. The lateness of the recent amendments, which rewrote the bill, do not allow for the necessary time for analysis and input by the legislature or relevant stakeholders such as county behavioral health departments providing these services, conservators and public guardians that administer LPS conservatorships, as well as judicial officers that would be involved in CARE proceedings.
>
> **Concerns with Senate Bill 28, June 11th Amendments**
>
> […]
>
> **Creates new involuntary pathways to CARE following conservatorship termination or long-term participation in voluntary treatment.** Conservatorship of an individual is one of the most extreme measures taken for individuals who are gravely disabled, part of which requires an investigation of all available alternatives to conservatorship and is only recommended if no suitable alternatives are available. Pursuant to state and federal law, counties are required to consider the least restrictive treatment options available. Conservatorships are terminated after one year unless the conservator determines further conservatorship is required, however this does not consider situations in which the conservatorship ends but additional services are deemed necessary. SB 28 creates a pathway in which individuals who have had their conservatorship terminated, but need a continued level of care, could be involuntarily funneled into CARE court. In addition, this bill would also establish CARE eligibility for individuals who have been undergoing voluntary treatment, but have not been clinically stabilized, citing high utilization of any emergency services, whether related to their behavioral health condition or not, a sign someone is not clinically stable. Given that federal policies will soon mean that thousands of Californians will lose access to Medi-Cal coverage, many more individuals may need to access emergency departments for their physical health needs, for example.
>
> […]
>
> **Requires sharing of confidential health information with various new parties.** Under HIPAA, counties can already share sensitive medical information with other providers for the purpose of care coordination. Consideration of state and federal privacy laws is a requirement for county behavioral health and other covered entities. As such, CBHDA is concerned with expanded requirements to share personal medical information as proposed with individuals and agencies without consideration of state and federal privacy protections.
>
> **Requires counties to develop an "expedited assessment" as an alternative to a 14 day assessment when receiving a CARE referral from a facility.** Given that 14 days is already a brief timeline to schedule and perform an assessment, and there is no clear indication of the quality of information or access to be provided by the facility, along with workforce challenges, CBHDA has serious concerns with this requirement which would add significant new costs to CARE. In the alternative, facilities sending CARE petitions should ensure

sufficient lead time for CARE petitions and robust, quality discharge planning processes to ensure individuals do not fall through the cracks upon discharge.

Requires the office of the Governor to annually release a list of counties prioritizing CARE Court implementation, known as CARE Champions, and counties experiencing challenges with implementation who need technical support and training, known as CARE ICU (Improvement and Coordination Unit) Counties. CBHDA has significant concerns with this requirement as the determination of CARE Champions and CARE ICU counties was not based on a valid measure of success under CARE. CBHDA encourages the legislature to work with subject matter experts to develop independent and valid measures of quality and success under CARE, to be overseen by the Department of Health Care Services.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Psychiatrists (CSAP)
Two individuals

Opposition

All People's Health Collective
Anti Police-terror Project
Antiracist Md
Black Men Speak, INC.
Buccola Family Homeless Advocacy Clinic
Cal Voices
California Alliance for Retired Americans (CARA)
California Association of Mental Health Peer Run Organizations
California Association of Social Rehabilitation Agencies
California Coalition for Women Prisoners
California Peer Watch
California Public Defenders Association
California State Association of Counties (CSAC)
California State Association of Public Administrators, Public Guardians, and Public Conservators
California United for a Responsible Budget (CURB)
Canary Resistance
Cd11 Coalition for Human Rights
Center for Independent Living Berkeley
Centro Legal De LA Raza
Coalition on Homelessness
Community Lead Advocacy Program Clap
Corporation for Supportive Housing (CSH)
County Behavioral Health Directors Association of California
County Behavioral Health Directors Association (CBHDA)
Disability Community Resource Center
Disability Rights California
Disability Rights Education & Defense Fund (DREDF)

Drug Policy Alliance
Food Not Bombs
Homeless United for Friendship and Freedom
Housing Is a Human Right
Independent Defense Counsel Office, County of Santa Clara
Justice2jobs Coalition
Kelechi Ubozoh Consulting
LA Defensa
Law Foundation of Silicon Valley
Los Angeles Community Action Network
Mental Health America of California
National Alliance to End Homelessness
National Homelessness Law Center
Painted Brain
People's Homeless Task Force Orange County
Project Return Peer Support Network
Rural County Representatives of California (RCRC)
Senior and Disability Action
Urban Counties of California (UCC)
Venice Justice Committee
Western Regional Advocacy Project

Analysis Prepared by: Kristian Wright / JUD. / (916) 319-2334